Georgia Department of Community Health

Division of Health Planning
2 Peachtree Street, NW
34th Floor
Atlanta, GA 30303

2004 ANNUAL RADIATION THERAPY SERVICES SURVEY (RTSS) INSTRUCTIONS

January 1, 2004 through December 31, 2004

- IMPORTANT NOTICE ABOUT SURVEY ACCURACY -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

2004 RADIATION THERAPY SERVICES SURVEY ACCESS FORM

The 2004 Radiation Therapy Services Survey (RTSS) is a Microsoft Access database. Versions of the survey are available for use with Microsoft Access 97 and Microsoft Access 2000. If your facility does not have Microsoft Access software, please contact the Division of Health Planning to obtain a hard copy of the survey. To determine if you have Microsoft Access you can click the “start” button on your computer and select the “programs” menu. Microsoft Access should appear among the listed programs if it is installed on your computer

IF YOU NEED ASSISTANCE

When you are working in the database, you may view these instructions by clicking the Help button found on each form. You can get specific instructions for any **item in blue** on the form by clicking the item.

If you can't find the answer to your problem on the Help screens, check the "Frequently Asked Questions" document on the web page where you downloaded the database. This document will be updated periodically as new questions arise.

If you still have any questions after reviewing the documentation above, contact Carlos Williams at (404) 656-0464 or by email at **cawilliams@dch.state.ga.us**.

INSTRUCTIONS FOR SUBMITTING THE DATABASE

The deadline for filing the completed survey database for your facility is March 25, 2005.

Once you have completed your Survey Database and resolved any data validation issues, you should submit the database to the Department of Community Health (DCH) via e-mail. Please send only an electronic version. ***Do not fax or mail a hard copy***. Please follow the steps below:

1. You must sign the Signature Form before submitting the database. The Primary Care Plan Summary will not be deemed complete without an authorized signature.
2. Please be sure to print a copy of your completed forms before submission and retain a copy of the Access file for your records.
3. To submit your database, click the "Email to DCH" button on the Opening Screen and follow the instructions. A zip file will be created that you can easily attach to an email message. Send the email message to: dchsurveys@dch.state.ga.us . Attach additional files as necessary (see below). After you send the message, you can check the Sent-Items box in your email program to see if the message was sent. You will not get an automated reply from DCH. ***Note that if you revise your survey, you must click the "Email to DCH" button again in order to update the zip file before resending it.***
4. If the Email button does not work, close the database and create a new email message using your email program. Attach the database to the message as you would any file. The database should be located at C:\DCH unless it was moved after being downloaded initially. The database file will have an MDB extension. If your email system does not allow MDB attachments, you will need to rename the file before you send it. Change the MDB extension to MDX.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided, edit check, error messages, and validation rules must be addressed or in balance and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division the survey is considered a public record. DCH staff may not be able to process your survey immediately due to high volumes of email messages and survey submissions. You may follow-up a few days after submitting your survey to make sure your message was received and that your survey was processed and is considered complete by the Division of Health Planning. Even if processed at a later date, the completed survey will be deemed complete on the day in which they were received at the dchsurveys email box. On or after the survey due date the completion status of all surveys for each facility will be published on the DCH website**. It is extremely important that you retain a copy of your completed survey (both in Access and in hard-copy) in case DCH did not receive the email or the attachment could not be processed.**

Revising or Amending the Survey – Pursuant to Rule 111-2-2-.04(1)(e) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

INSTRUCTIONS FOR COMPLETING THE SURVEY FORM

The Access database file may either be saved to a single computer or to an internal computer network. The database can be placed on a network so that multiple users can access and complete (or review) the survey at different times. Please be sure not to make copies of the database. Only one version of the database should be sent to DHP. The Access file should open automatically to an opening screen where you can select a form to complete or view. You should be able to print a blank copy of the survey from the "print" button included on each form or from the opening screen. Enter your facility's data using the survey form. Please be sure to provide an answer in every question. If the question does not apply to your facility please indicate "not applicable". Access does not have a "save" feature like other applications. Each change you make to the form will be saved automatically.

INSTRUCTIONS FOR COMPLETING THE SIGNATURE FORM

The database contains two types of forms. The first type is the survey form described above. This form is used to collect utilization data and information. The Signature Form is where the facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. A typed version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Form also will identify any out of balance edit checks and any validation rule criteria that are not correct. The edit checks must be resolved before the authorized signature will be accepted by the database. For example, if your total patient counts are not in balance when requested, then the Signature Form will indicate that they are out of balance and will not accept the authorized signature until the patient counts are corrected. In other cases, the form may provide a warning message indicating that certain data elements are out of balance or that certain responses are not valid either for your facility type or authorization. In these instances, unresolved issues must be addressed by an explanation in the provided comments box if the data is not changed or amended.

Data Validation Requirements – All edit and balance requirements and all required fields must be completed before the facility's administrator or chief executive can authorize the survey. You can determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button in the Data Validation Requirements section at the top of the Signature Form. This button produces the Data Validation Report containing a description of any out of balance totals and any required data items that are missing. The Data Validation Report can be printed and should be rerun until all items have been corrected. **Each item on the Data Validation Report must be corrected before the form will accept the authorized signature.**

PART A: GENERAL INFORMATION

Facility Name and Address – Please provide your Facility's current name and address as requested.

Medicaid and Medicare Numbers – Please enter the appropriate numbers for your facility. Do not enter dashes or alpha characters for either provider number.

Report Period - The required report period is 1-1-04 to 12-31-04. If the facility was in operation a full year, 12 months of data must be reported even if the ownership or management of the facility changed. It is the responsibility of the current owner or operating entity to obtain data from the prior owner/operator if necessary. Please note if the facility was not in operation for the entire report period.

PART B: SURVEY CONTACT INFORMATION

Please provide contact information for the individual authorized to respond to questions regarding your facility's survey.

PART C: OWNERSHIP, OPERATION & MANAGEMENT

Please provide the following information as applicable to your facility. If certain fields do not apply the form will allow you to enter only "Not Applicable" in the Full Legal Name column.

Owner - Provide the full legal name of the facility's owner and the owner's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change of ownership that has occurred since 12-31-03.

Operator - If the operating entity is other than the owner, provide the full legal name of the facility's operator and operator's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change in operating entity that has occurred since 12-31-03.

Manager - If a management contract is in effect, provide the full legal name of the facility manager and the manager's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change in management contractor that has occurred since 12-31-03.

Changes - If changes occurred during or after the report period, explain and include the effective dates of any change.

PART D: RADIATION THERAPY SERVICES/VOLUME

Please identify the number of units/machines by type operated by your facility. For each type of therapy, please report the utilization (number of total visits and number of patients) for the units/machines. In reporting workloads, patients should only be counted once per therapy (service) per report period whereas procedures, treatments and visits should reflect the total performed or delivered even if they were provided multiple times to one patient. Units should indicate the number of machines.

PART E. FINANCIAL AND UTILIZATION INFORMATION

Patients and Visits by Primary Payment Source - Report total patients (unduplicated) and number of treatment visits for patients by their primary payer source [Medicaid, Medicare, Third-Party (insurance or other), or self-pay]. Please report Peachcare for Kids patients as Third-Party. This table should reflect data for the entire report period. Please note that totals reported here should balance to totals reported elsewhere in the RTSS (because patients should be reported unduplicated).

Total Charges - Report the total charges for radiation therapy services provided by your facility during the report period.

Reimbursement - Report the actual reimbursement (presumably, something less than total charges) that your facility received for radiation therapy services provided during the report period. Actual reimbursement would account for contractual adjustments, bad debt, indigent and charity care, etc.

Indigent and Charity Care Charges - Report the total amount of charges attributed during the report period to patients who are classified as receiving indigent or charity care. Persons classified as indigent must meet the federal guidelines. Charity Care should be authorized in accordance with the written policy of the facility. If the charity care is provided on a sliding fee scale basis, only that portion of the patient's account that meets the facility's policy, and that are provided without expectation of payment, may be considered as charity care.

Indigent and Charity Care Patients - Report the total number of patients what were classified as indigent or charity care and for which charges were written off to indigent or charity care accounts.

Average Treatment Charge - Please report the average charge per treatment visit as of 12-31-04.

Utilization by Race/Ethnicity of Patient - Report the number of unduplicated patients and total treatment visits by race/ethnicity according to the indicated categories. These data are needed as an indication of the services rendered to population sub-groups. The totals here should agree with the number of patients and treatment visits reported elsewhere in the RTSS. The United States Census Bureau uses the following racial and ethnicity definitions:

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa. Terms

such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Multi-Racial: A person having racial origins from two or more of the above definitions.

Utilization by Age Grouping - Report the number of patients and treatment visits by the indicated age groupings. These data are needed as an indication of the services rendered to population sub-groups. The totals here should agree with the number of patients and treatment visits reported elsewhere in the RTSS.

State Cancer Registry - Please indicate whether your facility participates fully in reporting to the State Cancer Registry (Department of Human Resources, Division of Public Health).

PART F. PATIENT ORIGIN TABLE

Please complete the Patient Origin Table to reflect the county (or out-of-state) residence for each patient treated at your facility during the reporting period. You must enter the Facility UID on the first line. The UID will automatically display on subsequent lines. Be sure that Facility UID appears on each line. The county column has a pull-down menu listing all 159 Georgia counties in alphabetical order with out-of-state listings for AL, FL, NC, SC, TN, and all other following. Please select patient origin location from this menu and provide total number of patients and treatment visits for each origin location for the report period. The total number of patients and treatment visits must balance to those previously reported for race, age grouping and payment source.

PART G. COMMENTS

Please share any comments about the survey or survey process in general. We welcome your feedback and suggestions. Please reserve comments related specifically to your data or explanations for unresolved data issues for the comments section of the Signature Form.

The RTSS is due to the Department of Community Health by March 25, 2005. Please submit an electronic version using the following e-mail address:

dchsurveys@dch.state.ga.us

For questions regarding the RTSS or if you are unable to e-mail the RTSS file, please contact Carlos Williams with the Division of Health Planning at (404) 656-0464, or cawilliams@dch.state.ga.us.